Medicine and Law

The Duty to Protect Others From Your Patients—*Tarasoff* Spreads to the Northwest

JOSEPH D. BLOOM, MD, *and* JEFFREY L. ROGERS, JD, *Portland*

The California Supreme Court's Tarasoff *decision was the seminal case in the area of the duty to protect third parties from the potential of violence from patients.* Tarasoff*-related issues have now spread to many jurisdictions in the country. This article will pay particular attention to the cases influencing law in Washington and Oregon and will review the clinical duty to protect others from your patients that existed before* Tarasoff, *as physicians were taught to work between privilege and civil commitment statutes. The California law designed to limit* Tarasoff *liability and the reasons why legislators should be willing to support such legislation are discussed.*

(Bloom JD, Rogers JL: The duty to protect others from your patients—*Tarasoff* spreads to the Northwest. West J Med 1988 Feb; 148:231-234)

In 1974 and 1976 the California Supreme Court handed down landmark decisions in the *Tarasoff* case.[1,2] The court's 1974 opinion enunciated a legal duty for psychotherapists to warn possible victims of their patients' potentially violent acts. This decision produced significant turmoil in the mental health community. At the request of many professional organizations, the court agreed to reconsider its decision. Instead of abandoning the previously adopted duty to warn, however, the court's 1976 opinion expanded the action required of psychotherapists to include "whatever other steps are reasonably necessary under the circumstances." The duty to warn third parties was thus expanded into a more clinically relevant but broader duty to take preventive action or, as it is now being called, "the duty to protect." In this article we will first look at what clinicians were taught before *Tarasoff.* This will be followed by a discussion of the three major cases that influence clinical practice in Washington and Oregon. We will conclude with a discussion of the legislative steps now being taken in an attempt to limit liability in this difficult area.

Pre-Tarasoff Issues

One of us (J.D.B.) began psychiatric training in 1963. In the first weeks of training we learned that psychiatrists were to respect patients' confidential communications. At the same time, we were expected to act when we thought that a patient was either suicidal or homicidal. We gave this message to patients: What you tell me is confidential; however, if I decide that you are dangerous to yourself or to someone else, I am going to have to take action to prevent harm to you or to these persons. We had adopted a clinical duty to protect based on our assessment of what was primarily in the patient's and, only secondarily, in the community's best interests. Psychiatrists were taught to operate within a narrow legal framework defined by the statutes of privilege and civil commitment: one prohibited disclosure and the other allowed psychiatrists to reveal information in specific situations.

This legal framework still exists. Current Oregon statutes illustrate, on one hand, the strongly worded psychotherapist-patient privilege:

> A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purposes of diagnosis or treatment of the patient's mental or emotional condition among the patient, the patient's psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist, including members of the patient's family.[3]

The importance of confidentiality to the practice of medicine can be further illustrated by the Oregon Medical Practice Act. One of the grounds for suspending, revoking, or refusing to grant a medical license is "divulging a professional secret."[4] This statute reflects the long history of the importance of confidentiality in the doctor-patient relationship, which is deeply ingrained in the professional practice and ethics of medicine.

Civil commitment, on the other hand, allows physicians to admit mentally disordered patients to hospitals when a person is potentially dangerous to self or unable to care for his or her needs in the community. As defined in Oregon statute:

> "Mentally ill person" means a person who, because of a mental disorder, is either:
>
> (a) Dangerous to self or others; or
>
> (b) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.[2]

Before the *Tarasoff* decision, then, clinicians operated in a system in which it was necessary to steer a course between respecting or revealing a patient's disclosures based on a model that was concerned primarily with the protection of the patient. There existed a clinical duty to protect. The following is a discussion of actions before the creation of a legal duty to protect.

Case Example

One of the authors (J.D.B.) held a regularly scheduled psychiatric clinic in a rural town. The clinic was coordinated

From the Department of Psychiatry, Oregon Health Sciences University School of Medicine, Portland.

Reprint requests to Joseph D. Bloom, MD, Department of Psychiatry, Oregon Health Sciences University School of Medicine, 3181 SW Sam Jackson Park Rd, Portland, OR 97201.

ABBREVIATIONS USED IN TEXT
PSRB = Psychiatric Security Review Board
VA = Veterans Administration

by the local family practitioner, who did a fair amount of counseling on his own and scheduled the difficult psychiatric consultation questions and the severely mentally ill patients for the psychiatrist. During one visit he referred a teenaged boy who was having school discipline problems. The administration at the local high school had recently changed, and the school had become more conservative and discipline-oriented. This young man was very angry at the new school authorities and was in constant trouble with them.

When seen by the psychiatrist, the young man was indeed very angry. He felt that his school had betrayed him and that his views were shared by other students. In addition, he had decided to do something about the problem. His father kept some dynamite at home and had taught him how to use it. He said that in the next few weeks he planned to dynamite the school at night when everyone had left the building. He stated that he was determined to carry out his plan. The psychiatrist and the family physician discussed the case and told the patient that we had to try to stop him from doing something that might injure someone and/or might ruin the patient's life. He was very angry when told that we needed to see him with his parents so that they would know what was going on.

A family conference was scheduled with the young man, his parents, the family practitioner, and the psychiatrist. The young man was asked to tell his parents about his problems at school and then to tell them what he intended to do about it. His mother became greatly agitated; his father was quietly thoughtful while his son told him he was going to blow up the school with the dynamite from the family tool shed. After considering the story for a long time, the father said, "Well, I think he can do it; he sure knows how to use dynamite. I guess I am going to have to take it away from him." The patient was seen individually after the family conference. He was now very angry at the physicians but continued to want to talk. On subsequent visits, his anger toward the school gradually subsided. Therapy was terminated and the school remained intact; no one at the school was ever informed of the threat.

The case was frightening then and is even more so now, given the *Tarasoff* decision. What would we do in a case like this now? Was the right thing done then?

The Tarasoff Decision and the Northwest Cases

The *Tarasoff* case flies in the face of the tradition of medicine just reviewed, where cases were handled, for the most part, by physicians and hospitals. *Tarasoff* broke new legal ground. The facts of the *Tarasoff* case have been described on numerous occasions.[7] The drastic change in medical tradition was justified by the California Supreme Court by a very stark view of the dangers of modern society.

> Our current crowded and computerized society compels the interdependence of its members. In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest.[1]

Three subsequent cases, all derivatives of the *Tarasoff* decision, currently influence law and medical practice in Washington and Oregon. The first is a California case from the Ninth Circuit Federal Court of Appeals, followed by cases from the Washington and Oregon Supreme Courts. Each will be reviewed briefly.

Jablonski v United States.[8] The plaintiff, Megan Jablonski, brought suit against the Veterans Administration (VA) for the wrongful death of her mother, Melinda Kimball, who was killed by the man she was living with, Phillip Jablonski. In July 1978 Phillip Jablonski had threatened Ms Jablonski's mother and had attempted to rape her. The mother decided not to file charges but attempted to have the police enter Jablonski into psychiatric treatment. The police called the nearby VA Medical Center and were told that Jablonski would be evaluated by a certain physician. The police spoke with another psychiatrist and advised him of Jablonski's prior criminal record and indicated that they believed Jablonski warranted inpatient treatment. The physician indicated that he would transmit this information to the evaluating psychiatrist but failed to do so.

Several days later Jablonski was evaluated at the VA Medical Center. During the examination the psychiatrist did learn that Jablonski had served a five-year sentence for raping his ex-wife and that four days earlier he had attempted to rape the plaintiff's mother. Jablonski indicated that he had undergone previous psychiatric treatment but refused to say where. Voluntary admission to hospital was recommended. When the patient refused, a return appointment was set. The psychiatrist's note indicated that he perceived Jablonski as dangerous but not civilly commitable.

Following the interview Ms Kimball and the psychiatrist met. She indicated to the psychiatrist that she was concerned about Jablonski's behavior, and the psychiatrist suggested that she leave him, at least during this time. No attempt was made to locate the prior medical records that would have indicated that Jablonski had homicidal ideation in the past and predicted future violent acts. Jablonski was seen again as an outpatient four or five days later. He still was perceived to be potentially dangerous, and his next appointment was scheduled for three days later. On the day before that next appointment, Ms Kimball went to Jablonski's apartment and, while there, was murdered.

The Federal District Court found the psychiatrists to be negligent in this case for failing to record and transmit the police department's recommendation, in failing to obtain medical records, and in failing to adequately warn the victim. The Veterans Administration appealed. The Ninth Circuit Court of Appeals affirmed the trial court's decision. It reasoned that the psychiatrists had a duty to protect Ms Kimball. The court found sufficient evidence that the physicians breached their duty in all three ways identified by the trial judge. The court thought that if these three negligent failures had not occurred, action could have been taken to prevent the killing.

The VA hospital argued that physicians had no duty to protect Ms Kimball, as the patient had not specifically said he would harm her, and that she was not sufficiently targeted as a victim. The court rejected this argument, finding that lack of a specific threat was immaterial because Jablonski's past history indicated that he would likely direct his violence against Ms Kimball.

Although this was a California case, it was the first *Tarasoff*-type case decided by a court with jurisdiction in the Northwest—the Ninth Federal Circuit includes Oregon and

Washington as well as California and several other western states.

Petersen v State of Washington.[9] On May 14, 1977, the plaintiff, Cynthia Petersen, was injured in an automobile accident in Tacoma, Washington. While making a lawful turn at an intersection, she was struck by a vehicle driven by Larry Knox after he ran a red light while traveling at more than 50 miles per hour. Witnesses said Knox was under the influence of drugs. At the time of the accident, he was on probation for a 1975 burglary for which he had been given a 15-year suspended sentence on the condition that he participate in mental health counseling and refrain from drug use.

Five days before the accident he had been released from a Washington state hospital, where he had been admitted to hospital under Washington's civil commitment statute. A month earlier he had cut out his left testicle. While in the hospital, he was treated with neuroleptic medication. Just before his discharge, he was allowed to go home on a pass and was required to return that evening to the hospital. On his return from his pass he was found driving recklessly on the hospital grounds by security personnel. He was still released the following morning with a discharge diagnosis of a schizophrenic-like reaction due to drug use. He was thought to be in contact with reality and back to his "usual personality and behavior." Five days later the accident occurred. It was later learned that he had discontinued taking his medications after discharge from the hospital. Some time after the accident, Knox raped a woman and murdered both of her parents. At that time he was examined by two psychiatrists, who said that he was schizophrenic. This evidence was admitted into the Petersen trial bearing on the question of his diagnosis.

The Washington State Supreme Court, in upholding the decision for the plaintiff, not only adopted a *Tarasoff* standard but expanded it to include potential victims who could not be identified in advance. It held that the doctor "incurred a duty to take reasonable precautions to protect anyone who might foreseeably be injured by [the patient's] drug-related mental problems."

Cain v Rijken.[10,11] This case was brought by the personal representative of the decedent, who was killed in an automobile accident involving the defendant, Paul Rijken. At the time of the accident, Rijken was on conditional release to a day-treatment program in Portland and was under the supervision of the Oregon Psychiatric Security Review Board (PSRB). He had been found not guilty by reason of insanity on a prior charge and was placed under the jurisdiction of the PSRB,[12] which had put him in a monitored conditional release program in a community hospital operated by the PSRB.[13] While under that jurisdiction, Rijken had operated a motor vehicle in a reckless manner, speeding through an intersection and causing the accident that resulted in the death of the plaintiff. The trial court had granted a motion for summary judgment in favor of the mental health program, and, on appeal, the case focused on the issue of whether or not this program owed a duty to the plaintiff.

The court of appeals reversed the summary judgment and remanded the case for trial. Their ruling was based on several important factors. One was that the statute governing the Oregon PSRB makes it very clear that the primary function of the PSRB is to protect society. The second factor was Rijken's past history: Rijken had a diagnosis of schizoaffective psychosis characterized "by periods of manic activity, poor judgment and hallucinations." Several days before the automobile accident, he was reported to be in a deteriorated mental condition. His previous convictions, which had led to his placement under the supervision of the PSRB, included violating traffic laws, failing to remain at the scene of an accident, and attempting to elude arrest. Further background information included a longer history of misuse of his automobile, including previous traffic offenses. The appeals court stated that the program "knew that an earlier psychotic episode had resulted in Rijken driving recklessly and that Rijken's symptoms shortly before he caused the plaintiff's death indicated that his disease had become or was becoming active and was rendering him potentially dangerous to those of the class that the plaintiff was a member," namely, the driving public.

The Oregon Supreme Court affirmed the court of appeals' reversal of the summary judgment, holding that the hospital had a duty of reasonable care in treating patients and controlling their acts, that a breach of that duty creates potential liability to persons who are foreseeably endangered, and that a jury should be asked to decide if the risk to members of the public not specifically identifiable in advance was foreseeable in these circumstances. The court concluded that this case did not involve traditional negligence doctrines; rather, the duty to protect others was created by the Oregon Psychiatric Security Review Board statutes, which require protection of society. The court pointed out that its decision was not based on the *Tarasoff* doctrine. Nonetheless, although the legal doctrines have distinguishable bases, the practical effect for psychotherapists may be comparable, and the decision fits within the growing body of law developed following the *Tarasoff* decision.

The *Jablonski, Petersen,* and *Rijken* decisions extended the original *Tarasoff* doctrine in various ways. The *Jablonski* decision went beyond warning to the protection of identifiable victims, even when the victim already knew about the threat. In the *Petersen* case, a treating facility was found liable and, in *Rijken,* potentially liable for not taking the action necessary to protect foreseeable classes of victims even if no specific victim could be identified in advance. Both also extended the *Tarasoff* doctrine into the area of motor vehicle regulation. A recent article by Stone[14] described the extension of *Tarasoff* into the area of property damage. Notwithstanding the few cases that place confidentiality paramount to protecting third parties, it is clear that the *Tarasoff* doctrine is spreading.

Limiting the Scope of the Tarasoff Doctrine

Most recently we have seen the *Tarasoff* arena shift from the courts to the state legislatures. California's legislature became the first to pass a duty-to-protect statute[15]:

(a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

This statute attempts to limit liability to circumstances where there is a threat of violent behavior communicated to the psychotherapist against an identifiable victim or victims. The statute provides for discharge of the duty of the therapist

by his or her making a reasonable effort to communicate the threat to the potential victim or to a law enforcement agency. Bills similar to California's statute have recently been introduced into legislation in other states. Some of these go further by allowing discharge of the duty to be accomplished by the initiation of civil commitment. Some also add an additional statement exempting actions taken under these statutes from being considered as breaches of privilege.

It should be made clear that the duty to warn potential victims as described in the *Tarasoff* doctrine is separate and distinct from a clinical duty a physician may have to alert his or her patient to possible dangers inherent in a patient's medical condition. For example, conditions that affect a person's capacity to drive should be discussed with the patient, and, in some jurisdictions, reporting of such conditions is being required by statute and case law.

Although concerns are already being expressed about the value of statutes that attempt to limit *Tarasoff* liability,[16] there are powerful arguments that can be made to legislative bodies for limiting *Tarasoff*. There remains great respect for the protection of confidentiality and of privileged communications. Society benefits from such protections, and many legislators have supported strong privilege statutes.

There is also the ever-present quandary surrounding the prediction of dangerousness. Clear evidence exists of the inability of psychiatrists to predict long-term dangerousness.[17,18] The attack on the prediction of dangerousness has become more acute with the revitalization of death penalty statutes. It is now generally accepted that psychiatrists should not be making such predictions in forensic settings, and, by extrapolation, it seems logical to conclude that these predictions cannot be made accurately in office practices. Many legislatures have had to grapple with this problem in relation to other forensic matters, such as the insanity defense, dangerous offender, or death penalty statutes. The same argument can be made at this time for limiting the aspect of prediction in the *Tarasoff* doctrine.

Finally, there is the issue of the treatment of violent and potentially violent individuals. For public policy reasons, legislators should not want to handicap those therapists who are willing and able to undertake the treatment of violence-prone patients by reducing the therapist's inclination to take such persons into treatment.[19] For these reasons we would predict reasonable success for the limitation of the *Tarasoff* decision by state legislatures. The effects of these laws, once they are in place, on clinical practice awaits empiric study.

Conclusion

We have noted the spread of the *Tarasoff* doctrine and described recent cases, each of which added to the original formulation. This melding of the *Tarasoff* doctrine to the area of the dangerous offender brings another new dimension to the *Tarasoff* situation. Generally, insanity acquittees are considered by statutory definition to be dangerous persons. To some degree, so are many persons who have been civilly committed. Outpatient treatment of insanity acquittees and civilly committed patients is an important step forward. Many states are now recognizing the potential benefits of mandated outpatient treatment.

An unlimited *Tarasoff* doctrine is a threat to the development of community treatment resources for those mentally ill patients who are defined by statute as dangerous. Legislative limitation of the *Tarasoff* liability is one important step. Further legal steps such as the granting of statutory immunities may be necessary to nurture the mandated outpatient treatment system. This may become necessary should treatment centers be unwilling to place themselves in situations where liability may be confirmed almost by the very nature of the legal definition of the population they are attempting to serve.

REFERENCES

1. *Tarasoff v Regents of University of California*, 13 Cal 3d 177, 118 Cal Rptr 129, 529 P2d 553 (1974)
2. *Tarasoff v Regents of University of California*, 17 Cal 3d 425, 131 Cal Rptr 14, 551 P2d 334 (1976)
3. Or Rev Stat §40.230(2) (1984)
4. Or Rev Stat §677.190(5) (1983)
5. Or Rev Stat §426.175 (1987)
6. Or Rev Stat §426.005(2) (1987)
7. Mills MJ, Beck JC: The Tarasoff case, *In* Beck JC (Ed): The Potentially Violent Patient and the Tarasoff Decision in Psychiatric Practice. Washington DC, American Psychiatric Press, 1985
8. *Jablonski v United States*, 712 F2d 391 (9th Cir, 1983)
9. *Petersen v State*, 100 Wash 2d 421, 671 P2d 230 (1983)
10. *Cain v Rijken*, 74 Or App 76, 700 P2d 1061 (1985)
11. *Cain v Rijken*, 300 Or 706 717, P2d 140 (1986)
12. Rogers JL, Bloom JD, Manson SM: Oregon's psychiatric security review board: A comprehensive system for managing insanity acquittees, *In* Shah S (Ed): Mental Health and Law, Research and Policy. Ann Am Acad Polit Soc Sci 1986; 484:86-99
13. Bloom JD, Rogers JL, Manson SM: After Oregon's insanity defense: A comparison of conditional release and hospitalization. Int J Law Psychiatry 1982; 5:393-402
14. Stone AA: Vermont adopts Tarasoff: A real barn-burner. Am J Psychiatry 1986; 143:352-355
15. California Legislative Assembly Bill 1133 (1985)
16. Mills MJ, Sullivan G, Eth S: Protecting third parties: A decade after *Tarasoff*. Am J Psychiatry 1986; 144:68-74
17. Monahan J: The Clinical Prediction of Violent Behavior. Government Printing Office, 1981
18. Cocozza J, Steadman HJ: The failure of psychiatric predictions of dangerousness: Clear and convincing evidence. Rutgers Law Rev 1976; 29:1074-1101
19. Bloom JD: The *Tarasoff* decision, dangerousness and mandated outpatient treatment. Int J Offender Ther Compar Criminol 1986; 30:vii-x